CITY OF NEW ORLEANS
2025 CHOICE PLAN ACTIVE SUMMARY SHEET
PLEASE NOTE: There will be NO Medical Out-of-Network Coverage
Dental has a Health Coverage Plus Option for 2025 Plan Year
Vision Coverage WILL NOT change for 2025 Plan Year

UHC MEDICAL PLAN

Services	In Network	Out of Network
CALENDAR YEAR DEDUCTIBLE		
Individual	$750	Not Covered
Family	$2,250	Not Covered
OUT OF POCKET EXPENSES		
Individual	$4,500 (incl. deductible)	Not Covered
Family	$13,500	Not Covered
Maximum Lifetime Benefit	unlimited lifetime maximum	
OFFICE VISITS AND PREVENTATIVE CARE		
Office Visits	$30 co-pay	Not Covered
Wellness Visits	$0 co-pay	Not Covered
Specialist	$45 co-pay	Not Covered
OUTPATIENT SERVICES		
Laboratory, X-Ray, and Diagnostics, Outpatient	0%	Not Covered
Laboratory and X-Ray – Major Diagnostics (CT Scan, PET Scan, MRI, Nuclear Medicine) Outpatient	20% after deductible	Not Covered
Outpatient Surgery	20% after deductible	Not Covered
INPATIENT SERVICES		
Hospital	20% after deductible	Not Covered
Professional Services	20% after deductible	Not Covered
EMERGENCY SERVICES		
Emergency Room	$350 co-pay	Covered (emergency services only)
Urgent Care	$50 co-pay	Not Covered
Ambulance	20% after deductible	Covered (emergency services only)
MENTAL HEALTH SERVICES		
In-Patient	20% after deductible	Not Covered
Limit per Calendar Year	No stay limitation	Not Covered
Limit per Lifetime	No limitation	Not Covered
Outpatient Mental Health	$30 per visit	Not Covered
Limit per Calendar Year	No visit limitation	Not Covered
PRESCRIPTION DRUGS	$100 deductible	Not Covered
Generic (31 day supply)	$10 co-pay	Not Covered
Preferred (31 day supply)	$35 co-pay	Not Covered
Non-Preferred (31 day supply)	$70 co-pay	Not Covered
Mail Order Generic (90 day supply)	$30 co-pay	Not Covered
Mail Order Preferred (90 day supply)	$105 co-pay	Not Covered
Mail Order Non-Preferred (90 day supply)	$210 co-pay	Not Covered

UHC Dental BASE PLAN

Services	In Network	Out of Network
CALENDAR YEAR DEDUCTIBLE		
Individual	$0	$50
Family	$0	$150
ANNUAL ALLOWABLE AMOUNT		
Individual	$1,000 per person	$1,000 per person
DIAGNOSTIC SERVICES		
Periodic Oral Eval.	100%	100%
Radiographs	100%	100%
Lab and Other Diagnostic Tests	100%	100%
PREVENTIVE SERVICES		
Prophylaxis (Preventive)	100%	100%
Fluoride Treatment (Preventive)	100%	100%
Sealants	100%	100%
Space Maintainers	100%	100%
BASIC SERVICES		
Restorations	80%	80%
General Services	80%	80%
Simple Extractions	80%	80%
Oral Surgery (incl. surgical extractions)	80%	80%
Periodontics	80%	80%
Endodontics	80%	80%
MAJOR SERVICES		
Inlays/Onlays/Crowns	50%	50%
Dentures/Removable	50%	50%
Fixed Partials/Bridges	50%	50%

UHC Dental Health Coverage Plus Plan

ORTHODONTIC SERVICES – Up to Age 19 Only		
Annual Deductible	$0	$50 / $150
Orthodontia	50%	50%
Lifetime Ortho Max	$2,500	$2,500
Dental Implants (any age)	50%	50%
Implant Annual Max	$1,000	$1,000

UHC VISION PLAN

Services	In Network Per Calendar Year	Out of Network Reimbursement
Exam	$10 co-pay	$40
Frame Benefit Private Provider	$120-$150 (Retail Price)	$45
Frame Benefit	Retail Provider-$130	$45
Contacts	$105 Allowance	$105
LENSES (Standard)		
Single Vision	No co-pay	$40
Lined Bifocal	No co-pay	$60
Lined Trifocals	No co-pay	$80
Laser Vision Correction	Discount Available Please call 1-888-563-4497	

Please note that the Benefit Summary above provides a brief description of coverage. It is not a policy, certificate of insurance or coverage document. For complete details on coverage, exclusions, limitations, and the terms under which coverage may continue, please contact your customer service representative or review the Summary Plan Description.

HOW TO APPLY THE WELLNESS CREDIT TO YOUR WEEKLY / BI-WEEKLY PAYROLL (WELLNESS CREDITS DO NOT APPLY TO CHILDREN) BASE PLAN Healthcare Deductions Effective January 1, 2025 – December 31, 2025				
ACTIVE PARTICIPANTS	**Weekly**	**Bi-Weekly**	**Monthly**	**Projected Amount Paid by the City**
Employee Only (compliant)	$30.16	$60.31	$130.67	$478.83
Employee Only (non-compliant)	$33.62	$67.23	$145.67	$478.83
Employee & Child(ren) – (compliant)	$81.97	$163.95	$355.21	$770.08
Employee & Child(ren) – (non-compliant)	$85.43	$170.87	$370.21	$770.08
Employee & Spouse - EE/SP (compliant)	$101.78	$203.55	$441.03	$835.57
Employee & Spouse – (one non-compliant)	$105.24	$210.47	$456.03	$835.57
Employee & Spouse – EE/SP (two non-compliant)	$108.70	$217.40	$471.03	$835.57
Employee & Family – EE/SP (compliant)	$120.47	$240.94	$522.03	$1,242.64
Employee & Family – (one non-compliant)	$123.93	$247.86	$537.03	$1,242.64
Employee & Family – EE/SP (two non-compliant)	$127.39	$254.78	$552.03	$1,242.64

HOW TO APPLY THE WELLNESS CREDIT TO YOUR WEEKLY / BI-WEEKLY PAYROLL (WELLNESS CREDITS DO NOT APPLY TO CHILDREN) Health Coverage Plus Plan Healthcare Deductions Effective January 1, 2025 – December 31, 2025				
ACTIVE PARTICIPANTS	**Weekly**	**Bi-Weekly**	**Monthly**	**Projected Amount Paid by the City**
Employee Only (compliant)	$31.70	$63.41	$137.38	$478.83
Employee Only (non-compliant)	$35.17	$70.33	$152.38	$478.83
Employee & Child(ren) – (compliant)	$85.79	$171.57	$371.74	$770.08
Employee & Child(ren) – (non-compliant)	$89.25	$178.49	$386.74	$770.08
Employee & Spouse - EE/SP (compliant)	$105.13	$210.26	$455.56	$835.57
Employee & Spouse – (one non-compliant)	$108.59	$217.18	$470.56	$835.57
Employee & Spouse – EE/SP (two non-compliant)	$112.05	$224.10	$485.56	$835.57
Employee & Family – EE/SP (compliant)	$124.55	$249.11	$539.73	$1,242.64
Employee & Family – (one non-compliant)	$128.01	$256.03	$554.73	$1,242.64
Employee & Family – EE/SP (two non-compliant)	$131.48	$262.95	$569.73	$1,242.64

Revised 10/8/2024